



San Diego County  
Adult and Older Adult Mental Health Services

# Augmented Services Program (ASP) Handbook

DRAFT – Effective July 1, 2007

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## Table of Contents

I. Introduction	
A. Overview .....	1
B. History of ASP .....	1
II. Facility Eligibility	
A. Eligibility Requirement.....	2
B. Facility Waiting List .....	3
C. Change of Ownership .....	3
D. Training Requirement.....	3
III. Client Eligibility	
A. Eligibility Requirement.....	4
B. Pre-screening the client .....	4
C. ASP Scoring Tool.....	4
D. Clinical Override.....	5
E. Client Waiting List .....	6
F. Transfer of ASP Clients.....	6
G. Discharge Process .....	6
IV. Service Provision and Documentation	
A. ASP Client Service Requirements.....	8
B. Client Skill Assessment and Service Plan.....	8
C. Monthly Calendar .....	9
V. Monitoring the ASP Contract Facility .....	10
VI. ASP Monthly Billing and Payment .....	11
VII. Debarment and Exclusion Requirements .....	12
VIII. Appeals Procedure	
A. Provider Issue Resolution .....	13
B. Complaints and Appeals for Denial of Authorization or Payment for Services .....	13
C. Administrative and Contract issues with the County's Mental Health Program .....	13
IX. Glossary of Terms .....	14
X. Attachments .....	15
A. ASP Scoring Tool .....	15

B. Client Skill Assessment and Service Plan (CSASP) .....	17
C. Client Monthly Progress Report .....	21
D. Facility Billing Statement .....	23
E. Monthly Status Report .....	24
F. Program Census .....	26
G. Facility Billing Invoice .....	27
H. ASP Contractors' List, 2006 .....	28
I. ASP Flow Chart .....	30
J. Six-Month Outcomes Summary Form .....	31
K. Exclusion and Debarment Lists Verification .....	32
K.1 General Services Administration (GSA) and Office of the Inspector General (OIG) List of Excluded Individuals/Entities .....	32
K.2 Certification of Review of GSA Excluded Parties and Debarment Certification .....	33
K.3 GSA Debarment and OIG Exclusion List Checks .....	34

## **I. Introduction**

### **A. Overview**

This HANDBOOK is a simplified explanation of the contract requirements for the Augmented Services Program (ASP). It is intended as a quick reference for use by the facilities that contract to provide ASP services and by the Case Managers responsible for working with the facilities regarding their clients receiving ASP services.

ASP's basic philosophy is that some board-and-care clients with serious mental illness need additional services in order to achieve a higher level of daily functioning to remain in the community and out of institutions. ASP funds are provided specifically for the attainment of this overall goal. When hospitalization cannot be prevented, the focus of ASP shall be to shorten the length of stay by assisting with and expediting the return of clients to the community. The goal of the Augmented Services Program is to enhance and improve client functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific B&Cs with which the County has an ASP contract. Its emphasis is on developing client strengths, symptom management, and client self-sufficiency, and priority for ASP services is given to those people in most need of additional services. When clients no longer need ASP level of care due to improved functioning, they should be able to remain at the B&C and receive the B&C basic level of care.

The County-operated and contract-operated case management services who may refer to Augmented Services Program (ASP) include: County Case Management; Heritage Older Adult Case Management and FSP; MHS, Inc. Case Management (North and South ACT teams, North Star and Center Star); and Telecare ACCESS/ACT/REACH; Providence Catalyst; and Community Research Foundation IMPACT. Other eligible case management programs may be identified by the Program Monitor.

### **B. History of ASP**

ASP is a County of San Diego funded program which is a replacement of the Supplemental Rate Program (SRP). SRP was established on September 30, 1985 when Senate Bill-155 was signed by Governor Deukmejian. This Legislation provided for the implementation of a Supplemental Rate Program for residential care facilities serving the mentally disabled. In July 2002 SRP was replaced by the new ASP contract, as the State had previously discontinued specific SRP funding.

Currently, the County of San Diego Health and Human Services Agency (HHSA) contracts with some licensed B&C facilities to provide augmented services to persons with severe psychiatric disabilities. The additional services are reimbursed on a monthly basis through billing procedures with HHSA, Mental Health Services.







## II. Facility Eligibility



### A. Eligibility Requirements

In order to be eligible for ASP funds, a licensed board and care home (must have submitted a proposal in response to the County's Request For Proposal (RFP) and completed the contract process with the County of San Diego HHSA Purchasing and Contracting. The contract period is for one (1) year, with the County having an option to extend the contract for four (4) years, and up to an additional six (6) months beyond the expiration of the initial term.

When the contract is signed, the facility has agreed to all of the stated requirements in the contract. Those requirements are outlined in the contract and some are further explained in this handbook. Each facility's individual contract includes the ASP Statement of Work, its submitted proposal, any amendments, and this ASP Handbook.

To continue to be eligible to receive ASP funds, the facility must meet all requirements in the contract. At minimum, one annual site visit will be conducted by County Mental Health Services. The ASP Annual Site Visit is completed by the ASP Program Monitor (or Designee) who is responsible for monitoring the facility. Contract expectations include but are not limited to:

-  Licensure by the State of California Community Care Licensing Division (CCLD).
-  Keeping all insurance current, as specified in the contract, including:
  - ☐ Worker's Compensation
  - ☐ Automobile Insurance
  - ☐ General Liability Insurance
  - ☐ Professional Liability Insurance
-  Participation in annual mandatory ASP Contractor meetings.
-  ASP staff meet expectations of experience/training, and complete a minimum of 20 hours approved training each contract year. Four (4) hours of the 20-hour of training should address cultural competency issues.
-  Maintenance of client records in accordance with ASP contract and Handbook requirements.
-  Cooperation with ASP in allowing access to the Contractor's facility for purposes of monitoring and records review.

-  The contract ASP services were provided as per Client Skill Assessment and Service Plans (CSASPs) and contract requirements, including specific services described by the facility in their proposal.
-  Contractor shall not exceed a maximum of 67% ASP clients in its census, and shall actively participate in management of ASP census to ensure that highest-need clients are receiving the service.

Note that the County may terminate the facility from the ASP for any of the following reasons: 1) failure to maintain proper insurance; 2) failure to provide contracted services; 3) fraud or misuse of ASP funds; 4) ASP budget shortfalls requiring program cuts; 5) failure to maintain CCLD license; 6) for convenience of the County. If the Contractor wishes to terminate the contract for reasons other than those stated above, the Program Monitor must first approve the termination before taking effect.

## **B. Facility Waiting List**

There is no facility waiting list. The County of San Diego HHSA may contract with all competitive bidders.

## **C. Change of Ownership**

When a facility changes ownership, the current ASP contract may be terminated or continued through the novation process. The new owner is eligible to be a provider of ASP services if all County-established conditions are met and all requested information is presented to allow the County to do a thorough review of the proposed provider to ensure that there is capacity to provide ASP services.

## **D. Training Requirement**

The facility ASP employee, who is responsible for the provision of ASP services to clients, is required to obtain 20 hours of relevant mental health training per fiscal year. Four hours of the 20 hours of training should address cultural competency issues. Training hours will be credited for attendance at mandatory ASP meetings. ASP contractors are encouraged to send as many staff as possible to trainings and to the ASP meetings.

The ASP staff at the facility is responsible for providing training and guidance to all staff who are involved in providing ASP services. The ASP contractors shall make information and certification regarding all staff training available to the ASP Program Monitor (or Designee) as requested.

### **III. Client Eligibility**

#### **A. Eligibility Requirement**

In order to be eligible for funding from the ASP, a client must:

- 2) Have a DSM-IV-TR Axis I or Axis II primary diagnosis of a serious mental disorder;
- 3) Have an active case open to San Diego County Mental Health Services Case Management program and have been evaluated by his/her care coordinator to be in need of ongoing case management services. The assigned Case Manager is the only person who can submit a request for ASP services;
- 4) Need more than a basic B&C level of care to be able to successfully live in the community;
- 5) Score at a level that puts client within eligible range, which is dependent upon the current census of the program;
- 6) Reside in an ASP contracted facility at the time ASP funding begins; and
- 7) ASP funds must be available for the month(s) of service.

The client's case must remain open to the San Diego County Mental Health Services program that provides ongoing monitoring, care coordination and case management services in order for the ASP facility to continue receiving ASP funds for the client. The Case Manager should notify the ASP Program Monitor (or Designee) and the ASP facility prior to the time that he/she closes a client's case.

#### **B. Pre-Screening the Client**

The Case Manager screens the client prior to completing the ASP Scoring Tool in order to determine whether the client requires augmented services and whether the ASP facility can and is willing to provide the services a particular client requires. The Case Manager should evaluate whether the client requires extra time and attention, whether the facility will provide services and necessary expenditures on behalf of the client, and whether the client would have a difficult time finding placement elsewhere.

#### **C. ASP Scoring Tool**

The ASP Scoring Tool (Attachment A) was developed to evaluate clinical need and priority for ASP services. The overall score identifies the priority for ASP services assessed for the client by the Case Manager and the identified ASP program. The ASP Scoring Tool must be completed for each client prior to receiving ASP funding. ASP funding of a client will begin no earlier than the day the Scoring Tool is received by the San Diego County Mental Health Services ASP Program Monitor (or Designee) at the

fax number identified on the Scoring Tool. The ASP Scoring Tool may be periodically revised by the ASP Program Monitor (or Designee).

An ASP Scoring Tool may be completed by the Case Manager, with input by the ASP facility, prior to or during the client's placement in an ASP facility. The Case Manager may submit the Scoring Tool prior to the placement and request confirmation of acceptance into the program, informing ASP Program Monitor (or Designee) once placement has occurred.

The Case Manager completes the client's identifying information on the front page of the ASP Scoring Tool, and works with the client and the ASP facility to provide accurate assessment information. The facility has the responsibility to provide ongoing information to the Case Manager about the client's behavior and functioning. The Case Manager may use this information during the completion of the ASP Scoring Tool. The Case Manager may complete the ASP Scoring Tool by obtaining specific information for the ASP facility staff regarding services provided by the ASP facility. Submission of the completed ASP Scoring Tool by the Case Manager indicates that the Case Manager supports the client's ASP status.

The Case Manager faxes the completed ASP Scoring Tool to the San Diego County Mental Health Services ASP Program Monitor (or Designee) for review. The ASP Program Monitor (or Designee) reviews the client's score and determines acceptance or denial of ASP eligibility. Notice of ASP funding is issued by ASP Program Monitor (or Designee) when a client is initially approved for ASP participation.

The ASP Scoring Tool is to be completed every six months by the Case Manager, at which time it is forwarded to San Diego County Mental Health Services ASP Program Monitor (or Designee). Notice of completed six-month reassessment and renewed ASP funding will be issued and approved by San Diego County Mental Health Services ASP Program Monitor (or Designee). If a six-month reassessment is received more than 30 days late, the client may be discontinued from ASP.

The score is final. However, if the Case Manager believes that the score does not reflect the client's problem behaviors accurately, he/she should notify the ASP Monitor (or Designee) for further review.

#### **D. Clinical Override**

When a client does not score enough points to establish ranking priority, the ASP Program Monitor (or Designee) may override the assessment based on specific clinical information provided by the Case Manager. Formal written approval of the ASP Program Monitor (or Designee) must be received to enact the clinical override.



### **E. Client Waiting List, and Administrative Discharges to Accommodate Higher-Need Clients**

The ASP has limited funding, and the ASP Program Monitor (or Designee) manages ongoing use of available funding. When ASP funds cannot provide for every eligible high-need client, the ASP Program Monitor may institute a waiting list for potentially eligible clients, if requested by the Case Manager when the client is denied approval or is discontinued because of lower score. This list of potentially eligible clients is maintained by facility and in order of the client scores. As funding becomes available, the clients with higher scores (reflecting the most needs) will be funded for the ASP services. The facility will then receive the “Notice of ASP Funding” for the client. Because of ASP commitment to provide for the most severely disabled person first, it is possible that new clients scoring higher might replace already-funded clients with lower scores onto the waiting list. Clients placed from long-term care facilities and hospitals may be given higher priority for funding.

When an ASP facility is at its maximum capacity for ASP clients and a new referral needs ASP placement at the facility, the ASP Program Monitor (or designee) may examine each facility’s ASP caseload to determine which client at the facility least needs the ASP services if the person being referred is in greater need and administratively remove the current ASP recipient’s ASP eligibility. ASP facilities and Case Managers are encouraged to actively manage their ASP caseload and discharge from ASP any client who does not have major need for ASP services, to help optimize use of ASP services for those who most need it and to minimize the need for administrative discharges.

### **F. Transfer of ASP Clients from One ASP Facility to Another**

ASP clients who move between ASP facilities without interruption will continue to be eligible for ASP funding at the new facility, provided funds and an ASP slot at the receiving facility are available. No guarantee is made to the first facility to replace the client with another ASP client. The first facility must notify (via fax) the San Diego County Mental Health Services ASP Program Monitor (or Designee) of the discharge date and the second facility must notify (via fax) San Diego County Mental Health Services-ASP Program Monitor (or Designee) of the date of admission. A change of address and a change of Case Manager, if applicable, also should be faxed by the admitting ASP facility to the San Diego County Mental Health Services ASP Program Monitor (or Designee).

A new ASP Scoring Tool must be completed and submitted by the Case Manager to the San Diego County Mental Health Services ASP Program Monitor (or Designee) within 30 days of the transfer. The new ASP facility must begin documentation as though the client is a new ASP client. For example, a new CSASP must be completed and signatures obtained. Billing is started effective on the date of admission, if all other requirements have been met.

### **G. Discharge Process**

The ASP facility has to report to both the Case Manager and ASP Program Monitor (or Designee) on client discharge from his/her facility within seven days of client's discharge date. A financial consequence may be implemented if a facility fails to inform San Diego County Mental Health Services of the discharge within seven days of the discharge.

#### **IV. Service Provision and Documentation**

The ASP contractor is responsible for providing required documentation to the ASP Program Monitor (or Designee) as requested. All ASP documentation must be kept on site. Training documentation must be provided as requested directly to the ASP Program Monitor (or Designee). All documentation must be kept for three years.

##### **A. ASP Client Service Requirement**

Each facility described the service to be provided in its contract proposal. Services required by the County were outlined in the Statement of Work in the Request For Proposal (RFP). All stated services become a part of the signed contract and must be provided to fulfill contract requirements.

Group services are to be provided in the following areas, including but not limited to: medication awareness and education; special outings or events and socialization or recreational opportunities; shopping, cooking and housekeeping; money management; hygiene and grooming; educational and vocational activities; substance abuse education; use of community resources; interpersonal/communication skill building; and use of public transportation. Individual services are to be provided in the following areas, including but not limited to: transportation to medical appointments, day treatment, school, outpatient clinics, employment services, volunteer work, court, socialization or employment; special purchases for individual client needs for which there are no resources (i.e., SSI, Community Funds, etc.); incentives to encourage client involvement in working toward identified goals and objectives; and provision of close supervision of an intensive nature for clients who demonstrate such needs. These services should be provided to the clients who require them as listed on their ASP Client Skill Assessment and Service Plan (CSASP). Not all clients require all of the services. The services are to be provided through groups, classes and individualized support. The services should address learning of skills and development of resources, as well as reduction of problem behaviors. Service is to be offered as needed, including evening and weekend hours.

Every month, the Contractor shall complete the ASP Monthly Progress Report (Attachment C) for each ASP client. Every six months, the Contractor shall submit to the Program Monitor the ASP Client Six-Month Outcomes Summary Form (Attachment J).

##### **B. Client Skill Assessment and Service Plan (CSASP)**

It is the ASP facility's responsibility to complete the ASP CSASP (Attachment B) and obtain signatures from the Case Manager, ASP staff, and client within 30 days of the client's admission to the ASP and within 30 days of each six-month reassessment of ASP eligibility. The Case Manager can add or change items in the ASP CSASP to ensure that the services s/he recommends and which the facility has agreed to provide become a written part of the CSASP.

To complete the ASP CSASP, specific areas needing assistance are to be identified along the augmented services the facility will provide. The ASP facility should complete the ASP CSASP in consultation with the Case Manager and the client; other parties (e.g. involved family, treatment providers) may also be consulted. The CSASP is to be completed and signed within 30 days of ASP admission for all new ASP clients. The plan needs to be updated every six months or as needed, whichever is sooner; a plan needs to be fully rewritten at least yearly. New problem areas and services can be added at any time.

### **C. Monthly Calendar**

The facility shall provide the ASP Program Monitor (or Designee) with a monthly calendar that has the previous month's schedule for the ASP services being provided as described in the facility's proposal. (For example, the March calendar would be submitted in April.) All ASP activities including the special outings and events should be documented on the monthly calendar. Services listed in the facility's proposal must be reflected on the calendar. The calendar shall be submitted to Contract Support Services, no later than the tenth of the month, as part of the Monthly Status Report to San Diego County Mental Health Services.

## **V. Monitoring the ASP Contract Facility**

The ASP contract requires the facility to be monitored at least on an annual basis. The San Diego County Mental Health Services ASP Program Monitor (or Designee) may make both announced and unannounced visits to the ASP facility in order to monitor the provision of ASP services. At the time of the monitoring visit, the ASP Program Monitor (or Designee) notes the services that are being provided, samples client satisfaction with ASP services, and verifies that the relevant documentation has been completed in a timely manner.

The San Diego County Mental Health Services ASP Program Monitor (or Designee) verifies training completed by the facility. The San Diego County Mental Health Services ASP Program Monitor (or Designee) may consult with Community Care Licensing concerning any reported violations and may investigate any concerns that the ASP clients' Case Managers might have. The County Mental Health Contracts staff reviews and verifies each billing statement submitted by the facility prior to payment authorization.

When ASP contract requirements are not met, corrective feedback will be given in writing and the facility is required to complete a corrective action plan.

## VI. ASP Monthly Billing and Payment

ASP billing is submitted for eligible ASP clients after each calendar month of service delivery. The Monthly Status Report (Attachment E), the Facility Billing Statement (Attachment D), Facility Billing Invoice (Attachment G), and the optional ASP Program Census (Attachment F – this form may be used at Contractor's discretion), and the Exclusion and Debarment Certification (Attachment K.2) must be received by the 10<sup>th</sup> of the month following the provision of services. All billing statements received after the 10<sup>th</sup> of the month are held and processed on the 25<sup>th</sup> of the month. The County issues a check within 30 days of the date that the statements are processed based on when the County receives the invoice. Billing is based on the number of days billed. These rates are subject to adjustment in the case of private-pay clients (Adjusted ASP Rates).

All ASP clients are to be listed on the Facility Billing Statement with discharges, absences (including reason and return date), and total number of days the client was present at the facility during the month. County Contract Support Services reviews the statement, and the ASP facility is notified of any discrepancies before the billing is processed. As described in the Contract, payment for client absences may be made for up to ten days per month under specific circumstances (when the client has been at the facility for at least half of the month and the client's return from leave is not followed by discharge within 24 hours), and explanation of such shall be written on the billing statement; see Statement of Work for more specifics.

The Billing Statement must contain all of the requested information. The facility bills for the day of admission but does not bill for the day of discharge. The Billing Invoice Information (except for "amount") should be completed and signed: Contract Support Services will enter the amount based on the reviewed Billing Statement.

The County of San Diego is responsible for processing payment for ASP services. The Facility Billing Statement, the Facility Billing Invoice, the Monthly Status Report, and a copy of the Monthly Services Calendar are to be submitted directly to: **Contract Support Services, County of San Diego Mental Health Services, P.O. Box 85524, San Diego, CA 92186-5524, FAX: (619) 563-2730**

The ASP Contractor should notify the ASP Program Monitor (or Designee) if a payment is not received in a timely manner. The ASP facility must not contact the County Auditor and Controller directly.

The ASP payment rate is paid above and beyond the SSI/SSA Board and Care rate. Clients paying an amount higher than the SSI/SSA Board and Care rate are considered "private pay" clients and the amount that exceeds the SSI/SSA payment is subtracted from the ASP payment. The ASP facility and the Case Manager must report all private pay clients to the San Diego County Mental Health Services ASP Program Monitor (or Designee) so that the individual rates can be adjusted.

## **VII. Debarment and Exclusion Requirements**

Each claim for reimbursement you submit to the County must contain a certification (see Attachment K.2), signed by the person executing the claim, that no facility employee receiving funds from the ASP contract has been debarred or excluded from participation in Federal programs by the General Services Administration (GSA) and/or the United States Department of Health and Human Services Office of the Inspector General (OIG). Failure to include this certification on your claim for reimbursement will result in the claim being held and potentially disallowed. Any employee and/or subcontractor who appears on either the GSA or OIG lists are prohibited from working in any County funded program or interacting with any clients for whom you are receiving funds from the County. Additionally, these employees and/or subcontractors may be excluded from non-County related programs, and we encourage you to consult with your compliance office or legal counsel should any of your employees and/or subcontractors appear on either of the exclusion lists.

Sign the monthly debarment certification (Attachment K.2) only after you have compared a list of your employees and subcontractors each month (Attachment K.3) to the excluded parties listings maintained on the GSA and OIG websites (Attachment K.1). In accordance with Section 13.7 "Reports" of your contract, you must retain the records verifying that required checks have been performed and the names of the employees checked. Maintaining these records is vital to avoid any delays in your claim for reimbursement or potential disallowances.

## **VIII. Appeals Procedure**

### **A. Provider Issue Resolution**

The County's Mental Health Program recognizes that at times providers may disagree with the County's Mental Health Program over an administrative or fiscal issue. Providers are encouraged to communicate to their County's Mental Health Program Monitor (or Designee) any issue or concern regarding clinical decisions or claims and billing procedures. The County's Mental Health Program is required to respond in an objective and timely manner. The Program Monitor (or Designee) will always attempt to resolve the issue informally through direct contact with the provider. However, if the problem is not resolved to the provider's satisfaction informally, a formal appeal process is available.

### **B. Complaints and Appeals for Denial of Authorization or Payment for Services**

When the complaint concerns a denied or modified request for the County's Mental Health Program authorization or a problem with payment processing, providers have the right to access the provider appeal process at any time before, during, or after the provider problem resolution process has begun.

Providers appealing a denial of authorization or payment must submit a written complaint within ninety days of the receipt of the denial to their County Program Monitor. The written complaint should include the client name, date of authorization/payment denial and/or dates of all service(s) along with any specific information relevant to the complaint.

All such complaints will be logged and a response will be issued within thirty (30) days about action or denial. At any time providers may appeal any decision made by the San Diego County Mental Health Services ASP Program Monitor (or Designee) by submitting an appeal to the County Mental Health Director or his designee. The appeal should include the client name, date of authorization/payment denial and/or dates of all service(s) along with a copy of the San Diego County Mental Health Services ASP Monitor's letter of response. The County Mental Health Director or his designee will have thirty (30) days to make a final decision on the appeal and respond back in writing to the provider.

### **C. Administrative and Contract Issues with the County's Mental Health Program**

Issues concerning the County's Mental Health Program's administrative procedures, such as contract obligations or other general questions and concerns, should be directed to:

County Behavioral Health Services  
Contract Support Services  
P.O. Box 85524, San Diego, CA 92186-5524  
(619) 563-2733



### IX. Glossary of Terms

TERM	OPERATIONAL DEFINITION
<b>APPEAL</b>	Request in writing for a hearing to overturn a decision
<b>San Diego County Mental Health Services-ASP Program Monitor (or Designee)</b>	The San Diego County Mental Health Services-ASP Monitor &/or designate works in the San Diego County Mental Health Systems of Care Unit, and oversees the ASP. S/he will provide annual facility evaluations and ongoing oversight and coordination with the Case Manager and ASP providers.
<b>ASP SERVICES</b>	Supportive, supervisory and rehabilitative services provided by contracted ASP facilities, in addition to basic care and supervision required by Community Care Licensing (CCL).
<b>BOARD AND CARE</b>	Term used by ASP to refer to an Adult Residential Facility, Residential Care Facility for the Disabled, or Residential Care Facility. It is a home licensed to provide care and supervision to residents who are disabled by a severe psychiatric illness.
<b>CASE MANAGER</b>	Case Manager will refer to any mental health employee, County or contract, who is affiliated with an ASP-approved case management program and is the care coordinator for the client and is responsible for providing ongoing case management/brokerage services which shall include monthly monitoring of the client and assisting with obtaining medical care, financial stability, housing, day treatment and/or vocational services.
<b>CLIENT</b>	Refers to the person receiving services from San Diego County Mental Health who has been evaluated by his/her Case Manager and found to be in need of long-term case management service due to serious and persistent mental illness.
<b>CLIENT SUPERVISION</b>	ASP requires that all ASP services provided to clients/residents are to be coordinated by an ASP designated and trained facility staff.
<b>COMMUNITY CARE LICENSING DIVISION (CCLD)</b>	The State of California agency that is responsible for licensing and monitoring residential care homes.
<b>“HOLD HARMLESS”</b>	Agreement by which the County of San Diego is held harmless from any suit arising from the ASP contract.
<b>MONITORING</b>	San Diego County Mental Health Services review and verification of ASP facility services and requirements.
<b>ANNUAL ASP BOARD AND CARE MEETING</b>	Yearly convening of facilities and ASP staff to provide feedback, discuss changes and to review procedures regarding ASP service delivery. Facilities shall be notified of these meetings in a timely manner. Attendance is mandatory.

## X. ATTACHMENTS

A. ASP Scoring Tool .....	15
B. Client Skill Assessment and Service Plan (CSASP) .....	17
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E. Monthly Status Report.....	24
F. Program Census .....	26
G. Facility Billing Invoice .....	27
H. ASP Contractors' List, 2006 .....	28
I. ASP Flow Chart.....	30
J. Six-Month Outcomes Summary Form .....	31
K. Exclusion and Debarment Lists Verification .....	32
K.1 General Services Administration (GSA) and Office of the Inspector General (OIG) List of Excluded Individuals/Entities .....	32
K.2 Certification of Review of GSA Excluded Parties and Debarment Certification .....	33
K.3 GSA Debarment and OIG Exclusion List Checks .....	34

## San Diego County Adult and Older Adult Mental Health Services Augmented Services Program Scoring Tool

Client Name \_\_\_\_\_ InSyst # \_\_\_\_\_

Date of Scoring \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender M F

Case Manager \_\_\_\_\_ Primary Diagnosis (code and written diagnosis): \_\_\_\_\_

Case Management Program \_\_\_\_\_

Case Mgr's Phone # \_\_\_\_\_ Initial Scoring \_\_\_\_\_ or Six-Month Reassess \_\_\_\_\_

ASP Board & Care (circle one) : \_\_\_\_\_ *For County MH Admin Use Only –Date Form Received \_\_\_\_\_*

Broadway Home / Chipper's Chalet / Country Club / Fancor / Friendly Home II / Friendly Home-Mission Hills / Nelson-Haven / Orlando / VOA-Troy

1. Client is enrolled in a mental health intensive case management program (ACT, FSP, Intensive CM):  
☐ Yes (10 points)  
☐ No (0 points)
2. Client is one of the 100 "high utilizers" on the UBH "Targeted Inpatient Utilizers" list during the past 12 months:  
☐ Yes (10 points)  
☐ No (0 points)
3. Client has been discharged from an IMD within the past:  
☐ 6 months, or currently in an IMD (10 points)  
☐ 6-24 months (5 points)  
☐ >24 months, or never in an IMD (0 points)
4. Client has been an inpatient in either an acute psychiatric hospital or crisis residential facility in the past 12 months for:  
☐ >10 days (10 points)  
☐ 1-10 days (5 points)  
☐ None (0 points)
5. Client has had at least one eviction from a residential care facility in the past two years due to problem behavior/s.  
☐ Yes (4 points)  
☐ No (0 points)
6. Client is expected to move to a lower level of care (e.g., basic board and care) within 12 months, if additional support is given in any of the 7 major psychosocial skill areas listed on the ASP Progress Report:  
☐ Yes (10 points)  
☐ No (0 points)
7. ASP client expresses an interest or desire to participate in some aspect of ASP services and agrees to work toward improvement in any of the 7 major psychosocial skill areas of the ASP Progress Report:  
☐ Yes (5 points)  
☐ No (0 points)

If client is (or is planned to be) enrolled in the ASP program, the facility documents (or, if new admission, will document) specific interventions to assist client in acquiring or increasing the following skills (**beyond the level of support provided by a typical non-ASP B&C**):

8. Social/interpersonal/communicative behavior, as the client has a history of relationship disturbances which result in the need for additional support and guidance: Yes \_\_\_\_\_ (5 points); No \_\_\_\_\_ (0 points)
9. Independent living skills (e.g., shopping, cooking, housekeeping), as the client has difficulty in these areas and wants to increase level of self-sufficiency: Yes \_\_\_\_\_ (5 points); No \_\_\_\_\_ (0 points)

10. Mental health skills, including utilizing outpatient psychiatric treatment, as client needs specialized supports in this area:  
Yes \_\_\_\_ (5 points); No \_\_\_\_ (0 points)
11. Sobriety skills, as client has a history of chemical dependency/abuse and has relapsed in the past 12 months:  
Yes \_\_\_\_ (5 points); No \_\_\_\_ (0 points)
12. Money management skills:  
Yes \_\_\_\_ (5 points); No \_\_\_\_ (0 points)
13. Personal hygiene and grooming skills:  
Yes \_\_\_\_ (5 points); No \_\_\_\_ (0 points)
14. Using community resources (public transportation, vocational/educational classes, leisure and volunteer activities, etc.), as the client has otherwise been unable to access such resources: Yes \_\_\_\_ (5 points); No \_\_\_\_ (0 points)
15. Client has a physical condition that requires extensive services (**beyond the level of support provided by a typical non-ASP B&C**), including teaching client to manage the condition.  
\_\_\_\_ Yes (5 points)  
\_\_\_\_ No (0 points)
16. Client is 18-21 years old and has special needs re transitioning from the children's system of care.  
\_\_\_\_ Yes (5 points)  
\_\_\_\_ No (0 points)
17. Client is over the age of 55 and has a multiplicity of psychiatric, physical, and social impairments that require individual supervision and support from staff.  
\_\_\_\_ Yes (5 points)  
\_\_\_\_ No (0 points)

18. The following 12-part section is to be completed by the ASP Provider, based on its knowledge of the client's behavior. [If the client is newly referred, information should be based on history provided to ASP provider.] Each of the 12 areas should be rated as: **0 (none), 1 (minor), 2 (moderate), or 3 (extensive)**.

Client has exhibited the following behaviors with the past three months, which will be addressed by the ASP:

- \_\_\_\_ Easily victimized  
 \_\_\_\_ Stealing  
 \_\_\_\_ Fire-setting  
 \_\_\_\_ Threatening/intimidating behavior  
 \_\_\_\_ Violence toward self  
 \_\_\_\_ Violent toward others  
 \_\_\_\_ Violence toward property  
 \_\_\_\_ Disturbing others' sleep  
 \_\_\_\_ Bizarre behavior in public settings  
 \_\_\_\_ Refusing prescribed medication  
 \_\_\_\_ Substance abuse  
 \_\_\_\_ Other – Please specify up to one additional area of concern, if relevant: \_\_\_\_\_  
 \_\_\_\_ Subtotal for Question 18 (add up scores for the above 12 sections)

ASP Provider's Signature: \_\_\_\_\_

**Score Total:** \_\_\_\_\_ **Case Manager's Signature:** \_\_\_\_\_

Keep a copy of this in the client record, and FAX the original to: County Mental Health Administration, (619) 563-2761 (Attn: ASP). ASP funding will not start until the Scoring Tool is received. If client is not already at the B&C, send FAX notification on the day of admission so that funding will start that day. Access to this program is based on: (1) the client's score; and (2) the current number of people enrolled in this program (which has limited capacity).

Client Name: \_\_\_\_\_

Attachment A

**"DRAFT – DO NOT USE"**

CLIENT	DATE OF PLAN:
FACILITY NAME	CHECK TYPE OF NEEDS & SERVICES PLAN: <input type="checkbox"/> ADMISSION      and/or <input type="checkbox"/> UPDATE

**GOALS:**By the end of 6 months (from \_\_\_\_\_ to \_\_\_\_\_), I will be able to: (choose 1 to 2 most desired outcome/s for the **6-month period**)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Get symptoms under control                | <input type="checkbox"/> Improve social skills  | <input type="checkbox"/> Avoid having a relapse and having to go to the hospital |
| <input type="checkbox"/> Find a better place to live               | <input type="checkbox"/> Reduce side effects from my medications                          | <input type="checkbox"/> Other (Please specify): _____                           |
| <input type="checkbox"/> Learn the skills I need to live on my own | <input type="checkbox"/> Reduce use of alcohol &/or street drugs                          | _____  |
| <input type="checkbox"/> Return to school                          | <input type="checkbox"/> Learn about my illness, how to recover, and how to avoid relapse | _____  |
| <input type="checkbox"/> Develop job skills and get a job          |   |  |

**CLIENT STRENGTHS AND ABILITIES RELATED TO GOAL:**

- |  |   |
|--|---|
| <input type="checkbox"/> Determined                        | <input type="checkbox"/> Has previous work experience                   |
| <input type="checkbox"/> Listens to suggestions            | <input type="checkbox"/> Had been to school and studied/ finished _____ |
| <input type="checkbox"/> Seeks help when needed            | <input type="checkbox"/> Other (please specify): _____                  |
| <input type="checkbox"/> Open to learn                     | _____   |
| <input type="checkbox"/> Can express thoughts and feelings | _____   |
| <input type="checkbox"/> Gets along well with people       | _____   |

**BARRIERS, BEHAVIORS, SYMPTOMS OR OBSTACLES TO GOAL ATTAINMENT:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Difficulty coping with symptoms                 | <input type="checkbox"/> Few or no friends                 | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Difficulty managing side effects of medications | <input type="checkbox"/> Trouble getting along with people | _____  |
| <input type="checkbox"/> Shy   | <input type="checkbox"/> Not enough money                  | _____  |
| <input type="checkbox"/> No contact with family                          | <input type="checkbox"/> Drinking too much                 | _____  |
|  | <input type="checkbox"/> Using street drugs                |  |

**“DRAFT – DO NOT USE”**

	Skills Needed	Objectives to reach the stated Goal/s	Strategy/ies	Services provided by Facility		Status <i>(Include Date &amp; Initials)</i>	
				Activities	Frequency	1 <sup>st</sup> -6 <sup>th</sup> mos.	7 <sup>th</sup> -12 <sup>th</sup> mos.
<b>Social &amp; Interpersonal Skills</b>				<input type="checkbox"/> One on one _____ <input type="checkbox"/> Group _____ _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued
<b>Skills related to normative behavior</b>				<input type="checkbox"/> One on one _____ <input type="checkbox"/> Group _____ _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued
<b>Mental Health Skills</b>				<input type="checkbox"/> One on one _____ <input type="checkbox"/> Group _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved <input type="checkbox"/> Not achieved <input type="checkbox"/> Continued <input type="checkbox"/> Discontinued

**“DRAFT – DO NOT USE”**

	Skills Needed	Objectives to reach the stated Goal/s	Strategy/ies	Services provided by Facility		Status <i>(Include Date &amp; Initials)</i>	
				Activities	Frequency	1 <sup>st</sup> -6 <sup>th</sup> mos.	7 <sup>th</sup> -12 <sup>th</sup> mos.
<b>Sobriety Skills</b>				<input type="checkbox"/> One on one _____ _____ <input type="checkbox"/> Group _____ _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued
<b>Money Management</b>				<input type="checkbox"/> One on one _____ _____ <input type="checkbox"/> Group _____ _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued
<b>Physical Health &amp; ADL's</b>				<input type="checkbox"/> One on one _____ _____ <input type="checkbox"/> Group _____ _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued

**"DRAFT – DO NOT USE"**

	Skills Needed	Objectives to reach the stated Goal/s	Strategy/ies	Services provided by Facility		Status <i>(Include Date &amp; Initials)</i>	
				Activities	Frequency	1 <sup>st</sup> -6 <sup>th</sup> mos.	7 <sup>th</sup> -12 <sup>th</sup> mos.
Utilized Community Resources/ Socialization				<input type="checkbox"/> One on one _____ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued	<input type="checkbox"/> Achieved  <input type="checkbox"/> Not achieved  <input type="checkbox"/> Continued  <input type="checkbox"/> Discontinued

**First 6-month ASP Skill Assessment and Service Plan:**

Facility Staff \_\_\_\_\_ Date \_\_\_\_\_ Client \_\_\_\_\_ Date \_\_\_\_\_

Case Mgr. \_\_\_\_\_ Date \_\_\_\_\_

**Second 6-month ASP Skill Assessment and Service Plan Update:**

Facility Staff \_\_\_\_\_ Date \_\_\_\_\_ Client \_\_\_\_\_ Date \_\_\_\_\_

Case Mgr. \_\_\_\_\_ Date \_\_\_\_\_

**Note: A new plan needs to be written one year after this form was first written.**



# ASP Client Monthly Progress Report

21

Date \_\_\_\_\_

Facility \_\_\_\_\_

Client \_\_\_\_\_

Case Manager \_\_\_\_\_

## LEVEL OF PARTICIPATION IN MAJOR PSYCHOSOCIAL SKILL AREAS

SEEKS MENTAL HEALTH TREATMENT	ACQUIRES NEW SOCIAL SKILLS OR IMPROVES INTERPERSONAL BEHAVIOR	PERFORMS DAILY ADLs*	PRACTICES SOUND MONEY MANAGEMENT
<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never
REMAINS SUBSTANCE-FREE	ATTEMPTS TO ACHIEVE NORMATIVE BEHAVIOR**	UTILIZES COMMUNITY RESOURCES AND SOCIALIZATION ACTIVITIES***	NUMBER OF HOSPITALIZED DAYS AND LEVEL OF HOSPITALIZATION
<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Consistently <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely/Never	<input type="checkbox"/> Hospital <input type="checkbox"/> ER/EPU <input type="checkbox"/> Crisis Residential  <b>Baseline Data for 6 months prior to admission to ASP Services:</b> <input type="checkbox"/> # Of Previous Hospitalization days (include IMD days)

\* Activities of Daily Livings (ADLs) Hygiene, grooming, laundry, housekeeping skills

\*\* Not hostile, threatening, violent

\*\*\* Public transportation, vocational, leisure and volunteer activities

### Progress Key

Consistently 80-100% of the time  
 Often 60- 80% of the time  
 Sometimes 40-60% of the time  
 Occasionally 20-40% of the time  
 Rarely/never 0-20% of the time

Discharge date from ASP \_\_\_\_\_ to \_\_\_\_\_ (basic board and care; independent living;

☐ Eviction ☐ Planned D/C due to Client Improvement ☐ Other acute hospital; long term care, etc)

Six-Month Annual Review Date \_\_\_\_\_ (6-months from admit or date of discharge)

4/12/07 DRAFT Attachment C

## ASP Client Monthly Progress Report

22

Month & Year: \_\_\_\_\_

Facility Staff: \_\_\_\_\_

Client: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Facility Staff: For each group or individual activity completed, please write your initials in the box corresponding to the date on which the activity occurred. At the end of each month, add up the initials for each row and write the sum in the *Total* column.

Activity	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
<b>Group Services</b>																																
Medication Awareness & Education																																
Special Outings or Events & Socialization or Recreational Opportunities																																
Shopping, Cooking & Housekeeping																																
Money Management																																
Hygiene & Grooming																																
Educational & Vocational Activities																																
Substance Abuse Education																																
Use of Community Resources																																
Interpersonal/Communication Skill Building																																
Use of Public Transportation																																
Other:																																
<b>Individual Services</b>																																
Transportation to:																																
Medical Appointment																																
Day Treatment																																
School																																
Outpatient Clinic																																
Employment Services																																
Volunteer Work																																
Court																																
Socialization																																
Employment																																
Special purchases for individual client needs for which there are no resources (SSI, Community Funds, etc.)																																
Incentives to encourage involvement in working toward identified goals & objectives																																
Provision of close supervision of an intensive nature for clients who demonstrate such needs, which is consistent w/service plan																																
Other:																																

Notes: \_\_\_\_\_

AUGUMENTED SERVICES PROGRAM  
FACILITY BILLING STATEMENT

Make Check Payable to:

Address:

ASP USE ONLY

P.O.# \_\_\_\_\_

V.C.# \_\_\_\_\_

S.O.# \_\_\_\_\_

NAME OF CLIENT(S) List all ASP funded clients (include those not billed this month)	ADJUSTMENTS			Days Paid	Days Not Paid	Net Claim
	List Discharges, Absences, Reason and Return Date	From	To			
Total					Total	

I hereby certify that the clients listed above were cared for in my facility for periods and rates stated.

Signature \_\_\_\_\_ Facility \_\_\_\_\_ Date \_\_\_\_\_

Administrator/Operator

I hereby certify that to the best of my knowledge the above statement is correct and in accordance with the law.

ASP Staff \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH & HUMAN SERVICES AGENCY, MENTAL HEALTH SERVICES  
ASP MONTHLY STATUS REPORT**

24

Facility Name: \_\_\_\_\_

Month: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

Instructions: Please address the following for your program's last month of operation. Fax your report to the Contract Administrator at (619) 692-5548 by the 10<sup>th</sup> of the month. Thank you for your cooperation.

**I. Client Admissions, Discharges, and Hospitalizations**

Number of ASP Clients on 1<sup>st</sup> of month \_\_\_\_\_. Number of ASP Clients on last day of month \_\_\_\_\_.

Please list below all admissions, discharges, and hospitalizations for the past month.

Client Name	Date ADMITTED to board and care*	Date DISCHARGED from board and care	Reason for Discharge AWOL = 1; Eviction = 2; Higher Level of Care = 3; Lower Level of Care = 4; Incarceration = 5; Planned = 6; Other = 7	Hospital Admission Date (If client was not hospitalized during the previous month, indicate "none".)	Hospital Discharge Date (indicate "N/A" if the client is still hospitalized)	Type of Hospitalization (Psych or Med)	Reason for Hospitalization

\*Attach a copy of the Client Service Plan for each admission

**II. Program Activities**

Please attach a copy of monthly calendar of events for the past month. Additional comments/activities may be listed here:

# HEALTH & HUMAN SERVICES AGENCY, MENTAL HEALTH SERVICES

## ASP MONTHLY STATUS REPORT

25

### III. Serious and Reportable Incidents

Serious and reportable incidents are described below, along with the required timelines for reporting to County Mental Health Administration, Quality Assurance at FAX (619) 692-5548, telephone (619) 692-8360. Provide written notice using Community Care Licensing document "Unusual Incident/Injury/Death Report."

- Serious incidents, including injuries, accidents, victimizations, lawsuit, attempted suicides, or violation by contractor, as well as any unusual events. Serious incidents shall be reported to County Mental Health within 24 hours.
- Death notices shall be reported immediately by telephone. Written notice is also due within 5 working days.
- Client absence from your facility shall be reported to Contract Administration within 3 working days.
- The transfer of an ASP client to another facility shall be reported to Contract Administration within 3 working days.
- A violation of the general licensing requirements deemed by the licensing agency to constitute a serious deficiency.

The table below should be used to summarize all serious and other reportable incidents for the previous month. (If none, please indicate "none".)

Type of Incident	Date of Incident	Date of 1 <sup>st</sup> Report	Date Summary Sent to County Mental Health

### IV. Client (Consumer) Complaints or Grievances (if none, please indicate "none")

Type of Complaint	Date Complaint Documented	Date of Resolution	If Not Resolved, Date Referred On

### V. Staff

Please list all new hires and terminations (if applicable). Also list all ASP staff, including the name of the employee and the number of hours worked during the month (at least 2 hours per client per week).

Position Title	ASP Staff	Date of Hire (if new hire)	Date of Termination (if applicable)
	<input type="checkbox"/> Yes. Name _____ #hrs____ <input type="checkbox"/> No		
	<input type="checkbox"/> Yes. Name _____ #hrs____ <input type="checkbox"/> No		
	<input type="checkbox"/> Yes. Name _____ #hrs____ <input type="checkbox"/> No		
	<input type="checkbox"/> Yes. Name _____ #hrs____ <input type="checkbox"/> No		

## Augmented Service Rate Program Census

Facility \_\_\_\_\_

Month/Year \_\_\_\_\_

Indicate each day that the client was at your facility

[illegible]

**Legend:**

X = client present at midnight

H = hospital

T = therapeutic leave

**W = AWOL**

**I have provided the services to the above Client(s), as contracted with County of San Diego Health and Human Services Agency, Mental Health Services for the Augmented Service Program (ASP).**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_ UBH Approval: \_\_\_\_\_ Date: \_\_\_\_\_

# AUGMENTED SERVICES PROGRAM FACILITY BILLING INVOICE

DATE: \_\_\_\_\_

CONTRACT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CONTRACT NO: \_\_\_\_\_

PROGRAM NAME: \_\_\_\_\_

MONTH OF SERVICE	DESCRIPTION	AMOUNT
		\$
	TOTAL BILLING	\$

SIGNATURE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

## ASP Contractors as of 2006

Broadway Home  
2445 Broadway  
San Diego, CA 92102  
Phone # 619-232-7406  
Fax # 619-232-4234

Chipper's Chalet  
835 25<sup>th</sup> Street  
San Diego, CA 92102  
Phone # 234-5465  
Fax # 234-5467  
Email of Carla Sidlo: See Chipper's Chalet

Country Club Guest Home  
25533 Rua Michelle  
Escondido, CA 92026  
Phone # 760-747-0957  
Fax # 760-738-6237

Fancor Guest Home  
631/651 Taft Avenue  
El Cajon, CA 92020  
Phone # 588-1761  
Fax # 588-8348

Friendly Home II  
504 Ritchey Street, San Diego, CA 92114  
Phone # 263-2127  
Fax # 266-9152

Friendly Home of Mission Hills  
3025 Reynard Way, San Diego, CA 92103  
Phone # 297-1841  
Fax # 299-0511

Nelson-Haven Board & Care  
1268 22<sup>nd</sup> Street, San Diego, CA 92102  
Phone # (619) 233-0525  
Fax # (619) 232-3700

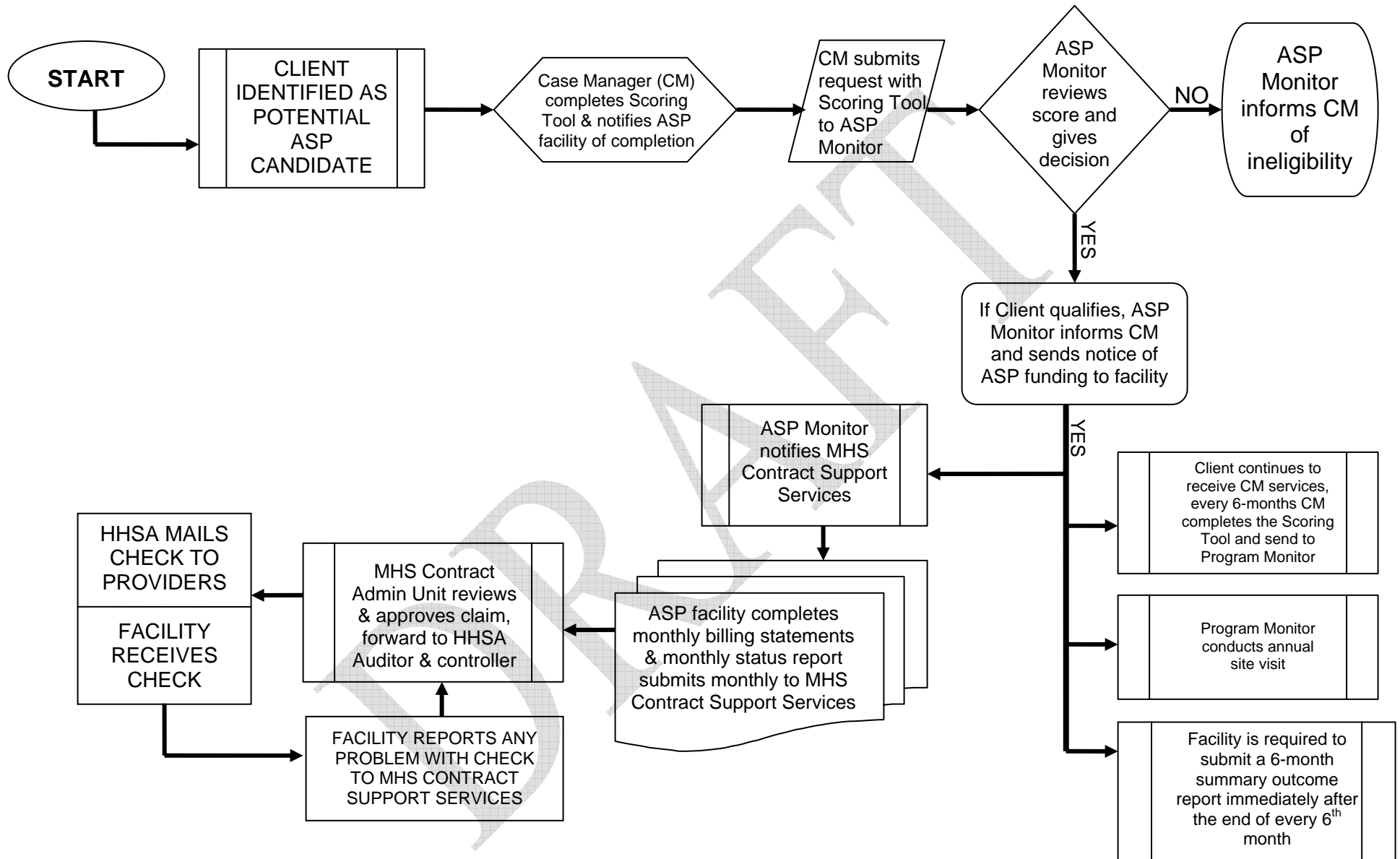


Orlando Guest Home  
299 Orlando Avenue, El Cajon, CA 92020  
Phone # 444-9411  
Fax # 444-0484

VOA Troy  
8627 Troy Street, Spring Valley, CA 91977  
Phone # 465-8792  
Fax # 465-3526

This program is open for referrals from designated County-funded mental health case management programs only. Please contact Debbie Malcarne with general questions about the Augmented Services Program at email [Deborah.malcarne@sdcounty.ca.gov](mailto:Deborah.malcarne@sdcounty.ca.gov)

## Augmented Services Program (ASP) FLOW CHART



**Instructions: Please complete this form using the information from each client's Six-Month Evaluation Report, and fax the completed Summary Form to Debbie Malcarne at fax # (619) 563-2760.**

### **ASP CLIENT SIX-MONTH OUTCOMES SUMMARY FORM**

Six-Month Period (please circle):    January 1<sup>ST</sup> - June 30<sup>TH</sup>        July 1<sup>ST</sup> - December 31<sup>ST</sup>        Year (please circle): 2007 2008

Name of Residential Care Facility \_\_\_\_\_ Name of ASP Administrator \_\_\_\_\_  
 Name of Primary ASP Direct Service Provider \_\_\_\_\_

OUTCOME #1: PSYCHOSOCIAL SKILLS	OUTCOME #2: HOSPITALIZATIONS	OUTCOME #3: DISCHARGES
# continuously enrolled ASP clients who showed improvement in at least 2 of the 7 areas on the service plan during this 6-month period: <div style="text-align: right; border: 1px solid black; width: 60px; height: 20px; margin-left: auto;"></div>	# continuously enrolled ASP clients hospitalized 2 times or more during this 6-month period: <div style="text-align: right; border: 1px solid black; width: 60px; height: 20px; margin-left: auto;"></div>	# of ASP clients enrolled for at least one month (does not have to be all within this 6-month period) who were discharged to a <b>less</b> restrictive level of care during this six-month period: <div style="text-align: right; border: 1px solid black; width: 60px; height: 20px; margin-left: auto;"></div>
Please list <b>initials</b> of these clients:	Please list the <b>initials</b> of these clients:	Please list the <b>initials</b> of these clients:

Total # clients who were continuously enrolled in the ASP program for the entire past six months:

Total # of hospitalization days for clients continuously enrolled for the entire past six months for the six months **prior** to entry into ASP:

Total # hospital days for all clients who were continuously enrolled in the ASP program for the entire past six months for this report period:

Total # clients enrolled in ASP for at least one month who were discontinued from ASP during this 6-month period:

Signed \_\_\_\_\_ Date \_\_\_\_\_

ATTACHMENT K.1  
General Services Administration (GSA)  
and  
Office of the Inspector General (OIG)  
Websites

EXCLUSION AND DEBARMENT LISTS VERIFICATION

To verify if someone is on the OIG Exclusion list, go to:

<http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html>

To verify if someone is on the GSA debarment list, go to:

<http://www.epls.gov/eplsearch.do>

To view the list of what will get someone placed on the OIG list, go to:

<http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html>

For assistance with any of the above sites or for assistance with lists not listed above, please call the Compliance Office at (169) 515-4244.

**CERTIFICATION OF REVIEW OF GSA EXCLUDED PARTIES AND  
THE OIG LIST OF EXCLUDED INDIVIDUALS/ENTITIES**

Claim Month:

Contract Name:

Contract Number:

I certify, under penalty of perjury under the laws of the State of California, that no employee providing services under the terms and conditions of this contract is currently listed on the GSA Excluded Parties Listing or the OIG List of Excluded Individuals/Entities.

\_\_\_\_\_  
Print Name/Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Position

**ATTACHMENT K.3**  
**GSA DEBARMENT AND OIG EXCLUSION LIST CHECKS**  
**FOR THE MONTH OF \_\_\_\_\_**  
**Contract No. \_\_\_\_\_**

[illegible]

**LISTS CHECKED BY:** \_\_\_\_\_  
(Signature)

DATE: \_\_\_\_\_

Page \_\_\_\_\_ of \_\_\_\_\_